Children's Administration - DSHS
CHILD FATALITY REVIEW
Sirita Sotelo

Report Date / System ID / Status	8/25/2005 - 1061 - Closed
Referral Number	1585920
Region Reporting	3
Office Name	Everett
Division	DCFS
Date Of Death	1/21/2005
Deceased Child's Name	Sotelo, Sirita Jimmina
Gender	Female
Date Of Birth	2/12/2000
Ethnicity/Race	Other
Has The Child Ever Been Placed In Out Of Home Care?	Yes
Legal Status At Time Of Death	Parental Custody
Official Type Of Death	Homicide (by Abuse)
Determined By	Medical Examiner
Case Status At Time Of Death	Closed
Cause Of Death	Traumatic bodily injury

Summary Of How Death Occurred

Law enforcement and medical aid were summoned to the home of the child victim at about 11:30 p.m. on January 21, 2005. The exact time of death was never precisely determined, but it was apparent to the first responders at the incident that the child was already dead at that time. The death appeared suspicious, and the Snohomish County Sheriff's Office (SCSO) interviewed those present who were capable of being interviewed (present at the time of first response arrival were the victim's father, stepmother, maternal aunt, four small half-siblings and the son of the maternal aunt). SCSO mapped the scene, took pictures, and collected other evidence.

The autopsy determined the victim had a skull fracture that extended from the top of her head down the back of her head. Her liver had been severed in two, and there was internal bleeding. She also had some facial bruising. Medical staff determined that death would have occurred very shortly, possibly even minutes, after the severing of the liver. All those interviewed in the home denied knowing how the victim may have died. They did say that the victim had possibly ingested some glue gun cleaner, and they had called Poison Control about this several hours before 911 was called. Poison Control said that the stated amount of the glue gun cleaner substance would not have hurt her, and advised giving milk to the child. The stepmother and maternal aunt also stated the victim may have fallen earlier in the evening when the stepmother was giving the victim a shower after the victim had defecated in her clothes.

Residence At Time Of Death	Family home
County Where Child Resided	Snohomish
Location Where Death Occurred	Family Home
County Where Death Occurred	Snohomish

Incident is not related to a facility

BIRTH / ADOPTIVE PARENTS

Adult Name (Last,First)	Role	Sex	DOB -- Age
Sotelo, Patricia Jo	biological mo of Sirita (non custodial), Birth Parent	Female	[redacted]/1964
	*Address:*Snohomish County Jail: *City/State:*Everett, WA : *Zip:*98201 :		
Ewell, John Henry	Caretaker, Adult Living In Home, Legal Guardian, Subject of CA/N Allegations, Birth Parent	Male	[redacted]1974
	*Address:*2502 101st Ave NE : *City/State:*Lake Stevens, WA : *Zip:*98258 : *Phone:*[redacted]:		
	*Caretaker Characteristics:*Criminal History, Substance Abuse, Familial/Environmental Stressors, Prior allegations of perpetrating CA/N		

STAFF AUTHORIZED TO ACCESS INCIDENT

Staff Name (Last, First)	Role	Phone	300 ID
Kaemmerlen Emily	HQ Staff		KAEM300
Meinig Mary	Other		MEIM300
Soule Tom	CI Supervisor	206-341-7356	SOTO300
Tupper Vickie	Administrative Assistant	(425) 339-4781	TUVI300
Hart Sandy	DCFS Area Manager		HASA300

NEGLECT AND/OR ABUSE ALLEGATIONS

Was There An Allegation Of Neglect By A Caretaker Regarding This Fatality In The Referral?	Yes
Was An Official Finding Of Neglect By A Caretaker Determined A Factor In This Death?	Yes
If Yes, Was It Physical Or Medical?	Physical

Neglect Issues Described

John Ewell was investigated regarding the allegation that he had been neglectful in the circumstances of this fatality. He ignored the unsanitary condition of his home in which there were many small children, and made no efforts to improve their situation. It is unknown if there was complicity with his wife, Heather Ewell, in

attempting to conceal the cause of Sirita's injuries. The allegation of negligent treatment or maltreatment was founded as to Mr. Ewell for the neglect of his children living in the home at the time.

Mrs. Ewell also had a determination of founded by CPS for negligent treatment or maltreatment against her regarding the other children living there due to the condition of the home.

Was There An Allegation Of Abuse By A Caretaker Regarding This Fatality In The Referral? Yes

Was An Official Finding Of Abuse By A Caretaker Determined A Factor In This Death? Yes

Abuse Issues Described

The stepmother to the victim was investigated by SCSO and CPS for the homicide of Sirita. She eventually pleaded guilty to manslaughter and has been sentenced to eight years. CPS has made a founded finding of child abuse against her for the death of Sirita.

SURVIVING SIBLINGS UNDER AGE 18

Child Name (Last,First)	Role	Sex	DOB -- Age	Ethnicity/Race	Legal Status
[redacted]	Sibling : Step-Sibling	Female	[redacted]/2004 -- 0yr-11mo	Caucasian	Parental Custody
	*Residence Type:*Family home : *Address:*[redacted] : *City/State:*Lake Stevens, WA : *Zip:*98258 : *Type of Death:*Not Applicable :				
[redacted]	Sibling : Step-Sibling	Male	[redacted]1999 -- 5yr-11mo	Caucasian	Parental Custody
	*Residence Type:*Family home : *Address:*[redacted] : *City/State:*Lake Stevens, WA : *Zip:*98258 : *Type of Death:*Not Applicable :				
[redacted]	Sibling : Half-Sibling	Female	[redacted]1996 -- 8yr-1mo	Caucasian	Parental Custody
	*Residence Type:*Family home : *Address:*[redacted] : *City/State:*Lake Stevens, WA : *Zip:*98258 : *Type of Death:*Not Applicable :				
[redacted]	Sibling : Step-Sibling	Female	[redacted]/2000 -- 4yr-4mo	Caucasian	Parental Custody
	*Residence Type:*Family home : *Address:*[redacted] : *City/State:*Lake Stevens, WA : *Zip:*98258 : *Type of Death:*Not Applicable :				

OTHER NON-SIBLING CHILDREN RESIDING IN THE HOME AT TIME OF DEATH

Child Name (Last,First)	Role	Sex	DOB -- Age	Ethnicity/Race	Legal Status
[redacted]	Other Living In Home : Other	Male	[redacted]/1999 -- 5yr-1mo	Caucasian	Parental Custody
	*Residence Type:*Family home : *Address:*[redacted] : *City/State:*[redacted]				

RCW 13.50.100 Children's Uniform...

WA : *Zip:*98258 : *Type of Death:*Not Applicable :

[redacted]

RCW 13.50.100 Child abuse information

CHILD PROTECTION / SAFETY PLANS / LICENSING ACTIONS

What Action Was Taken To Protect Other Children In Home/Facility?	Removed From Home/Facility
If The Child Remained In The Home/Facility, Was A Safety Plan Put Into Place?	N/A

Describe Safety Plan

All children in the home were placed initially, most with relatives.

What Licensing Actions Have Occurred As A Result Of This Death?

No prior child deaths in family and/or facility

ADULTS LIVING IN HOME/FACILITY WHERE DEATH OCCURRED

Adult Name (Last,First)	Role	Sex	DOB -- Age
Ewell, Heather Elaine stepmother to victim	Caretaker, Alleged Perpetrator, Present At Death, Adult Living In Home, Subject of CA/N Allegations, Step Parent	Female	[redacted]/1979
	*Address:*2502 101st Ave NE : *City/State:*Lake Stevens, WA : *Zip:*98258 : *Phone:*[redacted]		
	*Caretaker Characteristics:*History of CA/N as a Child, Substance Abuse, Familial/Environmental Stressors, Prior allegations of perpetrating CA/N		
	After this incident, Mrs. Ewell admitted to investigators that her childhood had been problematic. She disclosed that her father was drug addicted, abusive and had sexually molested her. Despite this, Mrs. Ewell allowed her father freely into her home.		
	Mrs. Ewell eventually admitted to inflicting the injuries that resulted in the victim's death.		
Ewell, John Henry	Caretaker, Adult Living In Home, Legal Guardian, Subject of CA/N Allegations, Birth Parent	Male	[redacted]/1974
	*Address:*2502 101st Ave NE : *City/State:*Lake Stevens, WA : *Zip:*98258 : *Phone:*[redacted]		
	*Caretaker Characteristics:*Criminal History, Substance Abuse, Familial/Environmental Stressors, Prior allegations of perpetrating CA/N		

	As the precise time of death was not established, it is unknown whether Mr. Ewell was present at the time of death.
[redacted] maternal aunt to victim	Witness, Present At Death, Adult Living In Home, Other Relative Female [redacted]1980
	Address:[redacted] : *City/State:*[redacted] WA : *Zip:*98[redacted]
	The residence of Ms. [redacted] is unclear. [redacted] lists her address as in Okanogan through September of 2005. When responding to inquiry of SCSO at the crime scene, Ms. [redacted] gave an address in Seattle as being where she and her son stayed during the week, and said they stayed with the Ewells on the weekends.
	Ms. [redacted] was known to be in the home sometime after the death of the child and prior to the call to 911.

RCW 74.13.500 74.13.310(1)(a) 42.17.310(1)(a) 74.04.060

CARETAKER CHARACTERISTICS

Adult Name (Last,First)	Role	Sex	DOB -- Age
Ewell, Heather Elaine stepmother to victim	Caretaker, Alleged Perpetrator, Present At Death, Adult Living In Home, Subject of CA/N Allegations, Step Parent	Female	[redacted]/1979
	*Address:*2502 101st Ave NE : *City/State:*Lake Stevens, WA : *Zip:*98258 : *Phone:*[redacted]:		
	*Caretaker Characteristics:*History of CA/N as a Child, Substance Abuse, Familial/Environmental Stressors, Prior allegations of perpetrating CA/N		
	After this incident, Mrs. Ewell admitted to investigators that her childhood had been problematic. She disclosed that her father was drug addicted, abusive and had sexually molested her. Despite this, Mrs. Ewell allowed her father freely into her home.		
Ewell, John Henry	Caretaker, Adult Living In Home, Legal Guardian, Subject of CA/N Allegations, Birth Parent	Male	[redacted]1974
	*Address:*2502 101st Ave NE : *City/State:*Lake Stevens, WA : *Zip:*98258 : *Phone:*[redacted]:		
	*Caretaker Characteristics:*Criminal History, Substance Abuse, Familial/Environmental Stressors, Prior allegations of perpetrating CA/N		

DECEASED CHILD CHARACTERISTICS

Child Name (Last,First)	Role	Sex	DOB -- Age	Ethnicity/Race	Legal Status
Sotelo, Sirita Jimmina	Primary Child : N-A (Primary Child)	Female	2/12/2000 -- 4yr-11mo	Other	Parental Custody : Prior Out of Home Placement(s)

*Residence Type:*Family home: *Address:*2502 101 ST AVENUE NE : *City/State:* Lake Stevens, WA : *Zip:*98258 : *Date of Death:* 1/21/2005: *Type of Death:*Unknown/Undetermined : *Behavioral Characteristics:* Prior out of home placement(s), Prior dependency action(s) :

FAMILY REFERRALS

Number Of Referrals Prior To Death	6
Date Of First Referral	1/20/2000
Date Of Last Referral	4/23/2003
Referral Notes	[Not Indicated]

LIST OF FAMILY REFERRALS

Referral Date	Referral ID	Subject	Program	CA/N Code	Finding	Decision	Actions Taken
4/23/2003	1409900	Fa allowed his other child to visit mo.	CPS	Physical Neglect	No Finding	Low Risk - Letter	
4/12/2003	1406869	Mother seen hitting Sirita--LE called	CPS	Physical Abuse	Inconclusive	Accepted	Legal Action, Other:return to court to ask for end to the unsupervised visits with mo
1/18/2002	1281337	Mo neglecting S in store--LE called	CPS	Physical Neglect	No Finding	Third Party	
3/13/2001	1191817	Allegations drugs sold from Ewell home	CPS	Physical Neglect	Info Only	Information Only	
2/13/2000	1072613	Newborn Sirita tests positive forcocaine	CPS	Physical Neglect	Founded	Accepted	Legal Action, Other:placement
1/20/2000	1064646	Pre-natal cocaine use by Ms. Sotelo	CPS	Pre-Natal Injury	Founded	Accepted	Service Plan

SERVICES OFFERED TO FAMILY

Substance Abuse	Offered/Accepted
Parenting Class	Offered/Accepted
Home Support Specialist	Offered/Accepted

Comments About Services Offered To Family

Services were offered, accepted, and included home visits and general case management by the private agency helping with the oversight of the transition of Sirita into the home of her father. It was agreed by the team that the offer of a Public Health Nurse into the home, had it been accepted, may have given an alert about Sirita's deteriorating condition.

FACTUAL SUMMARY OF THE CHILD/FAMILY CASE

Patricia Sotelo, the biological mother of Sirita, had previous CPS history in California. Her son was removed by CPS there, and she had some drug convictions. Ms. Sotelo first came to Washington CPS attention in 2000 when CPS received a referral that she tested positive for cocaine when pregnant with Sirita. When Sirita was born in February of 2000, both the mother and infant tested positive for cocaine. CPS filed for dependency and placed Sirita into care.

For the next three years, the Department attempted to remedy Ms. Sotelo's parenting difficulties and permanently reunite her with her daughter. The first reunification was only a few days after Sirita's birth when the Department asked the court to approve Sirita's return to her mother while she and infant were in an inpatient recovery program together. Reunifications were successful only for limited periods of time. After four failed attempts at reunification and seven different foster care placements, it became apparent that Sirita would have to have another permanent plan.

Sirita's father was identified as a man named John Ewell. Sirita, both parents claimed, was the product of a one night relationship between Ms. Sotelo and Mr. Ewell, who was married and had other children. Mr. Ewell remained with his wife and other children during Ms. Sotelo's pregnancy and during the years Sirita went back and forth between the care of her mother and foster care. Mr. Ewell had little to no involvement in the planning for Sirita. He said later that he had believed Ms. Sotelo when she told him that she was going to get Sirita back soon and then he could visit with Sirita. However, in May of 2003, the Department filed a petition for termination of parental rights on both parents. This was the beginning of a plan to move toward a goal of adoption for Sirita, as it appeared that neither parent was able and willing to raise Sirita. It was at this time Mr. Ewell stepped forward and said he was interested in having Sirita placed with him. He was living with his wife and three children at the time.

Mr. Ewell then came forward to comply with services the court required of him if Sirita was going to be placed with him. He obtained a chemical dependency evaluation, psychological evaluation, and attended parenting classes with his wife. In May of 2003, a home study of the Ewell home was conducted by an adoption home study worker. It consisted of one visit in which the worker was favorably impressed as she concluded her report with a recommendation that Sirita begin visits with the Ewells and be placed there in the immediate future "barring any additional adverse information." Mr. Ewell's criminal history consisted of two felony convictions for forgery and burglary. There was no criminal history found on Mrs. Ewell. A review of the family's CPS history revealed one information-only referral (not assigned for investigation). Sirita was eventually placed in the Ewell home in November of 2003. There was some limited supervision of the placement by both the private child placing agency involved in the case and the assigned social worker. The dependency was dismissed in November of 2004 as Mr. Ewell, by that time, had established a parenting plan and gained custody of Sirita through family court. The Department closed Sirita's case at that time.

On January 21, 2005, the aid car was called to the Ewell home. It was determined that Sirita was dead. Mrs.

Ewell later confessed to having beaten Sirita to death in a fit of rage over Sirita's having soiled her pants.

PARTICIPANTS IN REVIEW PROCESS

Reviewer Name (Last,First)	Title	City	Phone
Graham, Ruth	Foster parent		
Blanford, Joanna	CWS Supervisor		
Brandland, Dale	State Senator		
Stokes, Tom	Fatality Program Mgr		
Welch, Susan	Reg. 3 CPS Program Mgr.		
Hart, Sandra	Area Administrator		
Lawlor, Yen	Area Administrator		
Hart-Anderson, Cammy	Program Coordinator		
St. Clair, Mark	Lieutenant,Regional Task Force		
Nybo, Shane	VGAL Program Dir.		

INFORMATION USED IN REVIEW PROCESS

DCFS Case File / Summary Of File	Used in Review
Licensing File / Summary Of File	Not Applicable
DLR/CPS File / Summary Of File	Not Applicable
Autopsy Report	Not Available
Law Enforcement Reports	Used in Review
Prosecutor's Office Reports	Not Available
Coroner's Office Reports	Not Available
Medical Records	Used in Review
Records Of Contracted Provider	Used in Review
Death Certificate	Not Available
Criminal History	Used in Review
CPS Record Check	Used in Review

Comments About Information Used In Review Process

In addition to the listed sources of information used in this review, this fatality review committee also interviewed five social workers/supervisors that had been involved in some aspect of this case.

The following areas should be considered when answering the above questions. Intake policies and procedures; required time frames; required contacts; staffing and shared decision making requirements; supervisory reviews; legal authorities and requirements; risk assessment policies and procedures; documentation; other policies, practice, and systems issues appropriate to the case. Any specific personnel actions related to this case as a result of this review are not documented in this report.

IDENTIFIED ISSUES AND RECOMMENDATIONS

Category	Issue	Recommendation
Policy	The social workers involved in this case were at a disadvantage in not having full access to criminal history information. Having full access would have provided more information about father's offenses. The current system used to obtain criminal histories for CPS purposes is inadequate as there are often omissions in the report.	This review team recommends there be a statewide review of access by CA to criminal histories. This review should include Washington State Patrol and state legislators.
Practice	There were inadequate descriptions of the decision-making process involved in several critical events documented in this record. For example, documentation of the decision making-process to dismiss the termination petition was not documented in the record.	There should be additional training for social workers and supervisors on clear documentation of the background and reasoning in the decision-making process on crucial junctures in cases. These would be, for example, decisions to petition the court for dependency or termination of parental rights, or to request the court to withdraw petitions already filed. It would also include reasoning on placement decisions that do not flow logically from the narrative.
Policy	There was no reunification assessment completed prior to placement with the father and stepmother, as it was not required under the current policy when returning the child to the home of the parent who was not the parent from which the child was removed.	The review team recommends a change in policy to require reunification assessments when considering placement of a child with any parent after having been in out of home placement.
System	A law enforcement regional drug task force had information regarding this family that CA did not. Had CA been aware of this information, there would have been greater scrutiny of the household as a safe placement for Sirita.	The review team recommends that a meeting be arranged between CA and the law enforcement regional drug task force to include, at a minimum, the CA liaison to the task force and her supervisor to discuss the development of a system to identify common clients at most risk.
Practice	Although there were many instances in the record where references were made to visits with Sirita that were supervised by the Home Support Specialist, there was little to no documentation by her of	Supervisors of Home Support Specialists should ensure their staff are documenting their work with families.

	those visits, or any other of her activities on this case.	
Practice	The chemical dependency evaluation for the father was based on a self report which left out pieces of information that, had they been known to the evaluator, would likely have led to a different recommendation for treatment.	The father's chemical dependency assessment did not go through the established protocol with the chemical dependency liaisons put in place for this purpose. If the father had been referred through this program, there would have been an expanded assessment, with collateral information available to the evaluator, and a urine test. It is recommended that refresher training be made available to social workers/supervisors regarding how to access this expanded evaluation.
Contract	The case record shows that a private agency was paid approximately $175.00 per month by CA for the six months beginning when Sirita was placed with her father in November of 2003. This was for follow up services to Sirita to include, at a minimum, one home visit per month. The records sent to CA from the private agency's record state that all of their services to this family ended on February 3, 2004. However, payment continued through May of 2004.	The review team recommends that this case be referred for overpayment and contract monitoring issues.
Policy	The review team believed the in-home dependency (CA Policy 01-02) policy was unclear. The review team understood its intent was to direct the number of times a child is to be visited in the home when the child is being returned to a home from which s/he was taken and parental deficiencies were being remedied. It was not clear to the social worker and supervisor if this policy was to be followed when the child was being returned to the other parent. CA Policy 01-02 states, "...(this policy)...also does not apply when a child has been returned to a parent with no allegations of abuse or neglect concerning that parent. For example, if a child is placed with his/her non-custodial parent following the removal of the child from the custodial parent,	There is a new policy that clearly states, visits to children in their own homes should occur every thirty days. This review team recommends that this new policy carry over the more stringent monitoring requirements of CA Policy 01-02 (two visits to the child two times per month for the first six months home, and once per month thereafter for small children until the case is closed). This policy clearly applies to a child returning home to either parent after out of home placement.

	when there has been no allegation that the non-custodial parent has ever abused or neglected a child, this policy does not apply." The review team believed the provision in the in-home dependency policy left it rather ambiguous if the monitoring requirements should apply in this case.	
Practice	It was noted by several people involved in this case that services were needed for Sirita both in her previous placements and after placement in the home of her father. Therapy was never made available for Sirita through any of her placements, despite very problematic behaviors. The Ewell family did not receive services for Sirita after the last home visit of the assigned social worker in May 2004, and the family did not follow through on services they had planned to access.	Supervisors, in their monthly review of cases with their social workers, should specifically address the service needs of their client families and how these may best be met.
System	Removed from her mother at birth, Sirita went through many transitions back and forth in placements between her mother and foster care. There was delay in identifying and implementing a permanency planning goal for Sirita. This was in part due to intense efforts by parent focused advocacy groups for Sirita to be returned to her mother, despite evidence that the mother's parenting abilities were severely compromised. Collaboration was difficult due to the differing perspectives of Children's Administration and the parent advocacy group.	CA should do outreach and education with parent focused advocacy groups providing chemical dependency case management to work toward an environment that not only focuses on the interests of the parent, but also the best interests of the children. This would include initiating a conversation with CA regional staff, Division of Alcohol and Substance Abuse regional staff, Snohomish County Alcohol/Drug Coordinator, and the executive personnel of agencies providing chemical dependency case management. The purpose of this conversation would be to come to an understanding that the best interest of the child must be paramount, while simultaneously considering the parents' interests. It is important the alcohol and other drug treatment community recognize that while taking addictive substances out of their lives is a significant hurdle for a parent, there may remain other obstacles that compromise safe and effective parenting.
Practice	This review team, having heard from the social work staff that were close to this tragedy and from some that were affected more peripherally, believes staff suffered a trauma from this event that was not addressed quickly enough. The Employee Assistance Program	The team recommends that regional protocol be redesigned to assure more immediate and supportive response for staff immediately following a critical incident such as this. This would be in addition to, and preceding, the support of the Employee Assistance Program.

	debriefing was helpful, but the team perceived a need for something sooner.	
Practice	Staffing levels were inadequate at the time of this incident. Case coverage during vacations and uncovered supervisory and line positions contributed to excessive workload.	CA needs policy to address vacations and unfilled positions, including post-retirement buyout of vacation and sick time, which leaves those positions vacant during that time.
Practice	Sirita was in a total of seven separate receiving or foster homes over the three and a half years prior to her placement with her father. It is unclear from the record why, on the several times when Sirita returned to care from her mother's home, she was not placed with the same foster home she had been placed in previously.	The review team recommends that when a child is returned to care for whatever reason, there be a discussion and documentation of why s/he could not be returned to a foster or relative home s/he had been previously placed.

Approved By _____

Title _____

Given its limited purpose, a Child Fatality Review by Children's Administration should not be construed to be a final or comprehensive review of all of the circumstances surrounding the death of a child. Review is generally limited to documents in the possession of or obtained by DSHS or its contracted service providers and the panel may be precluded from receiving some documents that may be relevant to the issues in a case because of federal or state confidentiality laws and regulations. A review panel has no subpoena power or authority to compel attendance and generally will only hear from DSHS employees and service providers. The panel may not hear the points of view of a child's parents and relatives, or those of other individuals associated with a deceased child's life or fatality. A Child Fatality Review is not intended to be a fact-finding or forensic enquiry or to replace or supersede investigations by courts, law enforcement agencies, medical examiners or other entities with legal responsibility to investigate or review some or all of the circumstances of a child's death. Nor is it the function or purpose of a Child Fatality Review to take personnel action or recommend such action against DSHS employees or other individuals.